STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00115675. Complaint IN00115675 - Substantiated - Federal/state deficiencies related to the allegations are cited at F250, F279, 309, 319, 322, and F514. Survey dates: September 17 and 18, 2012 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Gloria J. Reisert MSW Census bed type: SNF: 5 SNF/NF: 65 Total: 70 Census payor type: Medicare: 10 Medicaid: 49 Other: 11 Total: 70 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 9/24/12 Cathy Emswiller RN			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically related social services to assist a new resident who was having difficulty in adjusting to the facility (Resident #E) and failed to ensure the family was fully informed of the changes in the health status and the resident's health care choices and their ramifications.(Resident #A). This deficient practice affected 2 of 6 residents reviewed for Social Services in a sample of 6 residents. Findings include: 1. Review of the clinical record for Resident #E on 9/18/2012 at 9:45 a.m., indicated the resident was admitted to the facility from another nursing home on 8/4/2012 and had diagnoses which included, but were not limited to: vascular dementia with disturbance of mood and behavior, panic disorder without agoraphobia, anxiety, gastrostomy tube placement, dysphagia and hemiplegia. Review of the nursing notes between	F0250	What corrective actions will be accompliashed for those residnets found to have been affected by the alleged deficient practice?Resident "E" care plan has been updated to reflect adjustment issues with interventions including psych services visit and incorporation of previous activity interests. Social services has met with resident E to assist resident in adjustment to facilitySocial Services has met with resident A and resident's family durina a care plan meeting to discuss wishes for future treatment in relation to her feeding tube and other advanced directives. The residents care plan has been updated to reflect her families wishes.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents experiencing behaviors at the facility have the potential to be affected by the alleged deficient practice.All staff will be re-educated on the facility behavior program including how to appropriately communicate regarding a behavior by 10/10/12 by SSD/designee.Post test included.Residents expressing a	10/12/2012

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	8/4/2012 and 9/18/2012 indicated the following entries: - "8/8/2012 at 10:00 a.m. - Res (resident) became very tearful this am crying loudly and asking for daughter saying 'I want out of here!! This isn't what I though it was going to be'..." - "8/9/2012 at 2:06 p.m. - ...Not as tearful today..." - "8/14/2012 at 6:45 p.m. - Res in room crying and saying she was going to die. Said she saw the tunnel and she was going to die. I assured her she wasn't going to die..." - "8/23/2012 at 7:22 a.m. - Res abed. Sleeping most of shift. When res woke she up she was very confused. Said she was very tired and wanted to know if she was going to die. I assured her she was not going to die. She also was stating her legs hurt and her arms. She was then talking to her Mickey Mouse doll beside her on the bed. She told him to shut up. I asked her if Mickey was talking to her and she said yes that he said he was in pain too..." Review of the Social Service documentation between 8/4/2012 and 9/18/2012 indicated a note dated 8/10/2012 which addressed an Admission		desire to re evaluste their advanced directives have the potential to be affected by the alleged deficient practice. Social services director will be educated by the social services consultant by 10/10/12 for how to identify and address residents advanced directive needs. All residents have been reviewd for changes in condition that may warrant discussions regarding advanced directive wishes.What measures will be put into place or what systemic changes you will make to ensure that the deficinet practice does not recur?All staff will be re-educated on the facility behavior program including how to appropriately communicate reagarding a behavior by 10/10/12 by the SSD/designee.Residents with behavioral issues will have a care plan developed with the interventions to assist in managing the behavioral issue.New or worsening behaviors will be reviewed by the IDT Monday through Friday, weekends will call the on-call nurse to assess cause, and update interventions to decrease cause.IDT reviews will include assessment of potential medical contributors, root cause and preventative intervention.Social services will meet with rsidents who are having adjustment difficulties and develop interventions to address adjustment.IDT will review	

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	Assessment on the resident's cognition, hearing, vision, communication skills and discharge plan. It also addressed the resident was to be seen by the psychiatrist next visit to manage psychiatric diagnoses and medications. A second note dated 8/15/2012 indicated the resident was evaluated by the psychiatrist on this date per staff and Physician request due to poor appetite and tearfulness at times. Documentation was lacking in which the Social Worker addressed the resident's difficulty with adjusting to placement, thoughts of dying and auditory hallucinations. During an interview with the Social Worker on 9/18/2012 at 4:25 p.m., she indicated she was not aware the resident had made the statements of thinking she was dying, not adjusting to placement, and the episode of auditory hallucination as she would have addressed the issues as well as making sure the psychiatrist was also aware. She indicated that she usually she would find out in the morning meetings if the residents were having issues and that the staff used to fill out behavior sheets whenever an issue like the statements of		interventions and progress to residents adjustment.IDT will review changes (including new or worsening behavior) for need to address advanced directive wishes. Social services/designee will inform families of behavior changes or changes in condition. IDT will ensure that notification is complete per medical record review. Residents/families will be contacted by social services director or designee for a care plan meeting to address. Residents/families will also be invited to care plan meetings on a quarterly basis or change in condition during which advan ced directives will be reviewed by the IDT.Social services/designee respnsible for complianceNon-compliance will result in re-education includiong disciplinary actionHow the corrective actions will be monitored to ensure the deficient practice will recur,.e., what quality assurance program will be put into place The Psychoactive Medications/Behavior management CQI tool will be utilized weeklyx4, then monthly thereafter by the SSD or designee for six months. Data will be submitted tot he CQI committee for review and follow-upThe care plan review CQI audit tool will be utilized weekly x4, then monthly thereafter by the SSD or designee for six months. Data will be submitted tot he CQI	

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	dying occurred but that she had put into place a new system in the computer at the end of August for Behavior Monitoring in which the staff enter an event occurrence, and then it would create a report she could review every morning. The Social Worker also indicated that because the staff were still trying to get used to her new system, she was still not always getting reports of issues. 2. Review of the clinical record for Resident #A on 9/17/2012 at 11:10 a.m. indicated the resident was re-admitted from the hospital on 5/18/2012 and had diagnoses which included, but were not limited to: dysphagia, diverticulosis and dementia. Review of the May 2012 nursing notes included, but were not limited to the following entries: - "5/1/2012 at 1:50 p.m. - Res discharged to [name of hospital] for g-tube placement." - "5/4/2012 at 4:41 p.m. - pt [patient] attempted to pull new g-tube out of placement this shift and site was bulging and reddened...MD notified and family notified and pt sent to [name of hospital] ER [emergency room] for evaluation of site and placement..."		committee for review and follow-upFindings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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The resident was subsequently admitted to the hospital until 5/18/2012 when she returned with an n/g tube [nasogastric].

- "5/19/12 at 2:35 p.m. - Resident removed NG tube at 1300 [1:00 p.m.]. New order received to replace NG tube with chest x-ray to verify placement...Resident tolerated procedure well..."

- "5/19/2012 at 7:27 p.m. - Res resting in bed. Received results from x-ray. Showed NG tube in stomach. Went to give res bolus feeding and meds. Res had pulled NG tube out. Stated 'I don't want that in.' ...Res agitated at this time. Not allowing nurse to replace tube. Will attempt when res calms down."

- "5/24/2012 at 11:30 a.m. - Res. pulled N/G tube out. [Name of Physician] phoned and notified with new orders to replace n/g and obtain stat x-ray to verify placement noted."

Between 12:45 p.m. on 5/24/2012 and 11:23 a.m. on 5/25/2012, the n/g tube was removed and replaced 3 more times due to difficulty in ensuring the tube was positioned correctly. At 11:23 a.m., because the resident was complaining of pain to head and neck, the physician gave

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	a new order for the resident to be sent to the ER for verification of tube placement. While in the ER, the n/g tube had been removed and replaced again to attain proper placement. - "5/28/2012 at 9:41 p.m. - Resident removed NG tube out of Nare [nose]. This writer notified MD, N/O [new order] Re-insert NG tube. N/O obtain x-ray via [name of x-ray company] to verify placement before resuming meds and feedings stat [immediately]..." - "5/30/2012 at 6:01 p.m. - Upon entering residents(sic) room, resident had pulled NG tube out of nose, notified MD of issue. N/O X-ray via [name of x-ray company] to verify placement of NG tube STAT. Place NG tube per policy..." On 5/31/2012 at 6:55 a.m., the resident was transferred to the [specialist physician] center for placement of a g/tube. During an interview with LPN #1 on 9/17/2012 at 12:05 p.m., she indicated the resident would often say that "it hurt" when referring to the NG tube and that she thought this might have been the reason for the resident pulling it out. Review of the Social Work			

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	documentation for May 2012 included an entry dated 5/23/2012 which described that a Significant Change Minimum Data Set [MDS] Assessment had been completed. Documentation was lacking in which a meeting with the resident's family had been held to discuss the incidents of the resident's frequent pulling out the NG tube and verbalizing she did not want it in and to determine what the family's wishes were for future care. During an interview with the Social Worker on 9/17/2012 at 2:40 p.m., she indicated the family had been aware each time the resident pulled the tube out and of the facility having difficulty getting it back in the proper place, but also indicated that the facility should have had a discussion with the family to discuss the situation as a whole and of the resident telling the facility she did not want the tube. During an interview with the family on 9/17/2012 at 3:10 p.m., she indicated that she was aware of the resident pulling out the tube and of the need for an x-ray which took a long time, but was not aware of how many times collectively it was pulled out and of how difficult it was for the facility to replace it in the correct position. She indicated that she was not aware the resident had told staff she did			

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	not want it in and of it hurting her/ The family member indicated that all she had been told by the facility was that the resident had to have the tube to eat, so she tried to convince the resident to at least try the tube. She also indicated she only wanted the resident to be made as comfortable as possible and not be in pain. On 9/18/2012 at 2:45 p.m., the Nurse Consultant presented a copy of the facility's current policy on "Care Plan review and Maintenance". Review of this policy at this time, included but was not limited to: "... Care Plan Guidelines: Purpose: Create an organized meeting on a routine basis with the purpose of communicating with families and residents important information about the well being and needs of the resident in a meaningful way. Help develop stronger relationships with families and residents to improve care..Change the social culture and encourage care plan meetings to focus on resident choices and preferences to enhance the resident's life." On 9/18/2012 at 2:10 p.m., the Accounts Receivable Manager presented a copy of the Social Worker's signed Job Description dated 1/2/12. Review of the Job Description at this time included, but was not limited to:"Summary Of Position			

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	Functions: The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential Position Functions: Assesses each resident's psychosocial needs and develops a plan for providing care. Reviews resident's needs and care plan with progress notes indicating implementation of methods to respond to identified needs...Provides assistance to residents in adjusting to the facility, exercising their rights as residents..." This Federal tag is related to Complaint IN00115675. 3.1-34(a)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop care plans which addressed a new resident's poor adjustment to the nursing home with beliefs of dying and auditory hallucinations (Resident #E); when a resident with an NG tube continually pulled it out (Resident #A); when a resident was placed on fluid restrictions and failed to list additional interventions necessary for the care of a dialysis resident (Resident #C). This deficient practice affected 3 of 6 resident reviewed for care plans in a sample of 6 residents.	F0279	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceResident E's care plan has been reviewed and updated to reflect adjustment issues with interventions including psych services visit and incorporation of previous activity interests. Social Services has met with Resident E to assist resident in adjustment to the facility.Resident A no longer has the n/g tube but has a g-tube-residents care plan has been reviewed and updated to reflect current plan of careResidents C's care plan has been reviewed and	10/12/2012

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	Findings included: 1. Review of the clinical record for Resident #E on 9/18/2012 at 9:45 a.m., indicated the resident was admitted to the facility from another nursing home on 8/4/2012 and had diagnoses which included, but were not limited to: vascular dementia with disturbance of mood and behavior, panic disorder without agoraphobia, anxiety, gastrostomy tube placement, dysphagia and hemiplegia. Review of the nursing notes between 8/4/2012 and 9/18/2012 indicated the following entries: - "8/8/2012 at 10:00 a.m. - Res (resident) became very tearful this am crying loudly and asking for daughter saying 'I want out of here!! This isn't what I though it was going to be'..." - "8/9/2012 at 2:06 p.m. - ...Not as tearful today..." - "8/14/2012 at 6:45 p.m. - Res in room crying and saying she was going to die. Said she saw the tunnel and she was going to die. I assured her she wasn't going to die..." - "8/23/2012 at 7:22 a.m. - Res abed. Sleeping most of shift. When res woke		updated to reflect current fluid restrictions and dialysis care/interventionsHow other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practicesLicensed nurses were in-serviced on developing plan of care for residents when completing a telephone order indicating a change of condition by the SDC/designee no later than 10/10/12. Post test included.All staff will be re educated on the facility behavior program including how to appropriately communicate reagarding a behavior by 10/10/12 by the SSD/designee. Post test included.Residents with behavioral issues will have a care plan developed with interventions to assist in managing the behavioral issue. Social services will meet with residents who are having adjusment difficulties and develop interventions to adress adjustment. IDT will review interventions and progress to residents adjustment.100% audit of all residents with fluid restrictions, G-tubes, and Dialysis and care plans were updated by DNS/designee-all on or before 10/12/12Change of condition/adjustment to facility/residents recieving dialysis/new or readmitted	

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	she up she was very confused. Said she was very tired and wanted to know if she was going to die. I assured her she was not going to die. She also was stating her legs hurt and her arms. She was then talking to her Mickey Mouse doll beside her on the bed. She told him to shut up. I asked her if Mickey was talking to her and she said yes that he said he was in pain too..." Documentation was lacking of a care plan by Social Services which addressed the resident's maladjustment to placement and decline in mood with auditory hallucinations. During an interview with the Social Worker on 9/18/2012 at 4:25 p.m., she indicated the resident's poor adjustment and mood issues could warrant a care plan and that one probably should have been written. 2. Review of the clinical record for Resident #A on 9/17/2012 at 11:10 a.m. indicated the resident was re-admitted from the hospital on 5/18/2012 and had diagnoses which included, but were not limited to: dysphagia, diverticulosis and dementia. Review of the May 2012 nursing notes		residents will be reviewed daily by the IDT/unit manager to ensure care plan was updated to reflect residents condition.All careplans are up to date relating to poor adjustment to facility, advanced directives, dialysis and food/fluid restrictions.Non compliance will result in further education including disciplinary action DNS/designee is responsible to ensure compliance with clinical care plansSSD/designee will be responsible for compliance of behavior programWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurLicensed nurses were in-serviced on developing plan of care for residents when completing a telephone order indicating a change of condition by the SDC/designee no later than 10/10/12. Post test included.All staff will be re-educated on the facility behavior program including how to appropriately communicate regarding a behavior by the SSD/designee by 10/10/12. Post test included.Social Services was educated on developing plan of care for any change in psychosocial concerns with residents by the SS Consultant/designee no later than 10/12/12. Post test included.100% audit of all residents care plans was completed/updated by the DNS/designee all on or before	

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	included, but were not limited to the following entries: - "5/1/2012 at 1:50 p.m. - Res discharged to [name of hospital] for g-tube placement." - "5/4/2012 at 4:41 p.m. - pt [patient] attempted to pull new g-tube out of placement this shift and site was bulging and reddened...MD notified and family notified and pt sent to [name of hospital] ER [emergency room] for evaluation of site and placement..." The resident was subsequently admitted to the hospital until 5/18/2012 when she returned with an n/g tube [nasogastric]. - "5/19/12 at 2:35 p.m. - Resident removed NG tube at 1300 [1:00 p.m.]. New order received to replace NG tube with chest x-ray to verify placement...Resident tolerated procedure well..." - "5/19/2012 at 7:27 p.m. - Res resting in bed. Received results from x-ray. Showed NG tube in stomach. Went to give res bolus feeding and meds. Res had pulled NG tube out. Stated 'I don't want that in.' ...Res agitated at this time. Not allowing nurse to replace tube. Will attempt when res calms down."		10/12/12Change of condition, admissions and re-admissions will be reviewed daily by the IDT/unit manager to ensure care plan was completed as neededAll care plans are up to date relating to poor adjustment to the facility, advanced directives, dialysis, and fluid/food restrictions.Non compliance will result in further education including disciplinary action DNS/designee is responsible to ensure compliance with clinical care plansSSD/designee will be responsible for compliance with the behavior programHow the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThe CQI tool for care planning will be utilized weekly x 4 weeks, monthly x 6 months and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%	

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	- "5/24/2012 at 11:30 a.m. - Res. pulled N/G tube out. [Name of Physician] phoned and notified with new orders to replace n/g and obtain stat x-ray to verify placement noted." Between 12:45 p.m. on 5/24/2012 and 11:23 a.m. on 5/25/2012, the n/g tube was removed and replaced 3 more times due to difficulty in ensuring the tube was positioned correctly. At 11:23 a.m., because the resident was complaining of pain to head and neck, the physician gave a new order for the resident to be sent to the ER for verification of tube placement. While in the ER, the n/g tube had been removed and replaced again to attain proper placement. - "5/28/2012 at 9:41 p.m. - Resident removed NG tube out of Nare [nose]. This writer notified MD, N/O [new order] Re-insert NG tube. N/O obtain x-ray via [name of x-ray company] to verify placement before resuming meds and feedings stat [immediately]..." - "5/30/2012 at 6:01 p.m. - Upon entering residents(sic) room, resident had pulled NG tube out of nose, notified MD of issue. N/O X-ray via [name of x-ray company] to verify placement of NG tube STAT. Place NG tube per policy..."			

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	On 5/31/2012 at 6:55 a.m., the resident was transferred to the [specialist physician] center for placement of a g/tube. During an interview with LPN #2 on 9/17/2012 at 1:20 p.m. and again at 2:40 p.m., she indicated there were concerns about taking the resident back with an NG tube as she was concerned that due to the resident's dementia, she might pull it out. Documentation was lacking of a care plan which addressed the use of the NG tube and the concerns the facility had with its placement in the resident's nose and her frequent removal of it. 3. Review of the clinical record for Resident #C on 9/17/2012 at 3:50 p.m., indicated that the resident was re-admitted to the facility on 8/24/2012 with diagnoses which included, but were not limited to: end stage renal disease, diabetes mellitus, dialysis, and renal failure. Review of the nursing notes and physician orders between 5/1/2012 and 9/17/2012, the resident was placed on 1500 cc [cubic centimeters] fluid restrictions on 3 different occasions - 5/25 to 6/15/2012 when the resident went to the hospital, on			

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	7/3 to 7/16/2012 when the resident went to the hospital, and on 9/12/2012 until present time. Review of the care plans for these time frames failed to locate a care plan which addressed the resident's fluid restrictions. On 8/14/2012, the resident returned from the hospital with new orders for dialysis 3 times a week. Review of the 8/14/2012 Admission Care Plan failed to check off the additional interventions listed for possible inclusion in the care of a dialysis resident. Among the additional interventions listed for possible inclusion were: "Assess dialysis shunt every shift. Monitor bruit and thrill. No B/P [blood pressure] or venipunctures in shunt site. Dialysis clinic phone number." This care plan with the missing additional interventions remained in effect for 10 days until a new one had been written. During an interview with the Minimum Data Set [MDS] Coordinator on 9/18/2012 at 10:35 a.m., she indicated that when a resident was first admitted, a temporary care plan would be developed, and then after their assessment, a master care plan would be developed to replace the temporary one.			

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	On 9/18/2012 at 2:45 p.m., the Nurse Consultant presented a copy of the facility's current policy on "Care Plan Review and Maintenance". Review of this policy at this time, included but was not limited to: "Policy: It is the policy of this facility that each resident will have a comprehensive plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs. Procedure:...care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...Care Plan Guidelines: Purpose: Create an organized meeting on a routine basis with the purpose of communicating with families and residents important information about the well being and needs of the resident in a meaningful way. Help develop stronger relationships with families and residents to improve care..." She also presented a copy of the facility's current policy on "Hydration Management". Review of the policy at this time included, but was not limited to: "...6. A comprehensive care plan will be			

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	written after the completion of the Hydration Assessment and review by IDT [Interdisciplinary Team] with specific resident needs and preferences as deemed necessary by IDT assessment..." This Federal tag is related to Complaint IN00115675. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interviews, the facility failed to assess a dialysis resident's shunt site for pain and condition of skin on a daily basis (Resident #C). This deficient practice affected 1 of 1 dialysis resident reviewed for shunt site condition in a sample of 6 residents. Finding includes: Review of the clinical record for Resident #C on 9/17/2012 at 3:50 p.m., indicated that the resident was re-admitted to the facility on 8/24/2012 with diagnoses which included, but were not limited to: end stage renal disease, diabetes mellitus, dialysis, and renal failure. On 8/14/2012, the resident returned from the hospital with new orders for dialysis 3 times weekly and had a shunt placed in his right jugular vein/right chest. Review of the 8/12 through 9/17/2012 Medication Administration Records	F0309	What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice.Resident C's is assessed daily for pain and condition of skin related to dialysis siteassessments are documented in the medical recordHow other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be takenAll residents recieving dialysis have the potential to be affected by the alleged deficient practiceLicensed nurses will be educated on assessing a dialysis residents access site for pain and skin condition on a daily basis and documenting on the MAR and/or dialysis flow sheet by the SDC/designee no later than 10/10/12. Post test includedDialysis assessments will be monitored daily by the charge nurse to ensure assessment of site is documented daily.Non-compliance with these practices will result in further education including disciplinary action.The Director of	10/12/2012

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	[MARs] indicated the following: - Access site _____ - check dressing site daily. Documentation was lacking of the access site being assessed as the blocks were blank and left no room for an assessment. On 9/17/2012 at 3:00 p.m., the Nurse Consultant presented a copy of the facility's current policy on "Dialysis Care". Review of the policy at this time included, but was not limited to: "...Procedure:...4. An assessment of the resident's dialysis access site will be completed daily to include bruit and thrill (if applicable), condition of skin at site, drainage, pain, warmth, redness and recorded on the Medication Administration Record (MAR) and/or dialysis flow sheet..." This Federal tag is related to Complaint IN00115675. 3.1-37(a)		Nursing/designee is responsible to ensure compliance.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur..Licensed nurses will be educated on assessing a dialysis residents access site for pain and skin condition on a daily basis and documenting on the MAR and/or dialysis flow sheet by the SDC/designee no later than 10/10/12. Post test includedDialysis assessments will be monitored daily by the charge nurse to ensure assessment of site is documneted daily.Non-compliance with these practices will result in further education including disciplinary action.The Director of Nursing/designee is responsible to ensure compliance.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThe CQI audit tool for dialysis care will be utilized weekly x4 monthly x 6 and quarterly thereafter. Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold.	

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F0319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. Based on record review and interview, the facility failed to ensure a resident who was experiencing difficulty in adjusting to nursing home placement, including thoughts of dying and auditory hallucinations, received appropriate treatment and services to help with accepting placement. (Resident #E). This deficient practice affected 1 of 1 newly admitted resident reviewed for adjustment in a sample of 6 residents. Findings include: Review of the clinical record for Resident #E on 9/18/2012 at 9:45 a.m., indicated the resident was admitted to the facility from another nursing home on 8/4/2012 and had diagnoses which included, but were not limited to: vascular dementia with disturbance of mood and behavior, panic disorder without agoraphobia, anxiety, gastrostomy tube placement, dysphagia and hemiplegia. Review of the nursing notes between 8/4/2012 and 9/18/2012 indicated the	F0319	What corrective actions will be accompliashed for those residnets found to have been affected by the alleged deficient practice?Resident "E" care plan has been updated to reflect adjustment issues with interventions including psych services visit and incorporation of previous activity interests. Social services has met with resident E to assist resident in adjustment to facilityHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents experiencing behaviors at the facility have the potential to be affected by the alleged deficient practice.All staff will be re-educated on the facility behavior program including how to appropriately communicate regarding a behavior by 10/10/12 by SSD/designee.Post test included.What measures will be put into place or what systemic changes you will make to ensure that the deficinet practice does not recur?All staff will be re-educated on the facility behavior program including how	10/12/2012

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	following entries: - "8/8/2012 at 10:00 a.m. - Res (resident) became very tearful this am crying loudly and asking for daughter saying 'I want out of here!! This isn't what I though it was going to be'..." - "8/9/2012 at 2:06 p.m. - ...Not as tearful today..." - "8/14/2012 at 6:45 p.m. - Res in room crying and saying she was going to die. Said she saw the tunnel and she was going to die. I assured her she wasn't going to die..." - "8/23/2012 at 7:22 a.m. - Res abed. Sleeping most of shift. When res woke she up she was very confused. Said she was very tired and wanted to know if she was going to die. I assured her she was not going to die. She also was stating her legs hurt and her arms. She was then talking to her Mickey Mouse doll beside her on the bed. She told him to shut up. I asked her if Mickey was talking to her and she said yes that he said he was in pain too..." Review of the Social Service documentation between 8/4/2012 and 9/18/2012 indicated a note dated 8/10/2012 which addressed an Admission Assessment on the resident's cognition,		to appropriately communicate reagarding a behavior by 10/10/12 by the SSD/designee.Residents with behavioral issues will have a care plan developed with the interventions to assist in managing the behavioral issue.New or worsening behaviors will be reviewed by the IDT Monday through Friday, weekends will call the on-call nurse to assess cause, and update interventions to decrease cause.IDT reviews will include assessment of potential medical contributors, root cause and preventative intervention.Social services will meet with rsidents who are having adjustment difficulties and develop interventions to address adjustment.IDT will review interventions and progress to residents adjustment.IDT will review changes (including new or worsening) for need to address advanced directive wishes. Social services/designee will inform families of behavior changes or changes in condition. IDT will ensure that notification is complete per medical record review. Residents/families will be contacted by social services director or designee for a care plan meeting to address. Social services/designee respnsible for complianceNon-compliance will result in re-education includiong disciplinary actionHow the corrective actions will be	

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	hearing, vision, communication skills and discharge plan. It also addressed the resident was to be seen by the psychiatrist next visit to manage psychiatric diagnoses and medications. A second note dated 8/15/2012 indicated the resident was evaluated by the psychiatrist on this date per staff and Physician request due to poor appetite and tearfulness at times. Documentation was lacking in which the Social Worker addressed the resident's difficulty with adjusting to placement, thoughts of dying and auditory hallucinations. During an interview with the Social Worker on 9/18/2012 at 4:25 p.m., she indicated she was not aware the resident had made the statements of thinking she was dying, not adjusting to placement, and the episode of auditory hallucination as she would have addressed the issues as well as making sure the psychiatrist was also aware. She indicated that she usually she would find out in the morning meetings if the residents were having issues and that the staff used to fill out behavior sheets whenever an issue like the statements of dying occurred but that she had put into		monitored to ensure the deficient practice will recur,.e., what quality assurance program will be put into place The Psychoactive Medications/Behavior management CQI tool will be utilized weeklyx4, then monthly thereafter by the SSD or designee for six months. Data will be submitted tot he CQI committee for review and follow-upThe care plan review CQI audit tool will be utilized weekly x4, then monthly thereafter by the SSD or designee for six months. Data will be submitted tot he CQI committee for review and follow-upFindings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	place a new system in the computer at the end of August for Behavior Monitoring in which the staff enter an event occurrence, and then it would create a report she could review every morning. The Social Worker also indicated that because the staff were still trying to get used to her new system, she was still not always getting reports of issues. This Federal tag is related to Complaint IN00115675. 3.1-43(a)(1)			

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F0322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on record review and interviews, the facility failed to assess a resident who had confusion and an NG tube for appropriateness of placement and ability to meet the resident's needs (Resident #A). This deficient practice affected 1 of 2 residents reviewed for feeding tubes in a sample of 6 residents. Finding includes: Review of the clinical record for Resident #A on 9/17/2012 at 11:10 a.m. indicated the resident was re-admitted from the hospital on 5/18/2012 and had diagnoses which included, but were not limited to: dysphagia, diverticulosis and dementia. Review of the May 2012 nursing notes included, but were not limited to the following entries: - "5/1/2012 at 1:50 p.m. - Res discharged to [name of hospital] for g-tube	F0322	What corrective actions will be accomplished for those residents found to have been affected by the deficient practiceResident A no longer has an N/G tube-resident has a g-tube and has been assessed for appropriateness of placement and ability to meet residents needs.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be takenAll residents with an enteral tube and dementia have the potential to be affected by the alleged deficient practice- Licensed nurses will be re-educated on assessing residents with dementia and an enteral feeding for appropriateness and ability to meet residents needs by the SDC/designee on or before 10/10/12. Post test included.If a resident is admissted with a n/g tube the DNS/designee will ensure residents are assessed for acceptance of n/g tube and appropriate placement by	10/12/2012

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	155697	A. BUILDING 00 B. WING	09/18/2012

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	placement." - "5/4/2012 at 4:41 p.m. - pt [patient] attempted to pull new g-tube out of placement this shift and site was bulging and reddened...MD notified and family notified and pt sent to [name of hospital] ER [emergency room] for evaluation of site and placement..." The resident was subsequently admitted to the hospital until 5/18/2012 when she returned with an n/g tube [nasogastric]. - "5/19/12 at 2:35 p.m. - Resident removed NG tube at 1300 [1:00 p.m.]. New order received to replace NG tube with chest x-ray to verify placement...Resident tolerated procedure well..." - "5/19/2012 at 7:27 p.m. - Res resting in bed. Received results from x-ray. Showed NG tube in stomach. Went to give res bolus feeding and meds. Res had pulled NG tube out. Stated 'I don't want that in.' ...Res agitated at this time. Not allowing nurse to replace tube. Will attempt when res calms down." - "5/24/2012 at 11:30 a.m. - Res. pulled N/G tube out. [Name of Physician] phoned and notified with new orders to replace n/g and obtain stat x-ray to verify		monitoring the resident and reviewing the medical record as needed.Non compliance with practices will result in further education including disciplinary actionDNSdesignee is responsible for complianceWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurLicensed nurses will be re-educated on assessing residents with dementia and an enteral feeding for appropriateness and ability to meet residents needs by the SDC/designee. on or before 10/10/12. Post test included.If a resident is admissted with a n/g tube the DNS/designee will ensure residents are assessed for acceptance of n/g tube and appropriate placement by monitoring the resident and reviewing the medical record as needed.Non compliance with practices will result in further education including disciplinary actionDNSdesignee is responsible for complianceHow the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThe CQI audit tool for enteral therapy will be utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%The CQI audit tool for enteral	

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	placement noted." Between 12:45 p.m. on 5/24/2012 and 11:23 a.m. on 5/25/2012, the n/g tube was removed and replaced 3 more times due to difficulty in ensuring the tube was positioned correctly. At 11:23 a.m., because the resident was complaining of pain to head and neck, the physician gave a new order for the resident to be sent to the ER for verification of tube placement. While in the ER, the n/g tube had been removed and replaced again to attain proper placement. - "5/28/2012 at 9:41 p.m. - Resident removed NG tube out of Nare [nose]. This writer notified MD, N/O [new order] Re-insert NG tube. N/O obtain x-ray via [name of x-ray company] to verify placement before resuming meds and feedings stat [immediately]..." - "5/30/2012 at 6:01 p.m. - Upon entering residents(sic) room, resident had pulled NG tube out of nose, notified MD of issue. N/O X-ray via [name of x-ray company] to verify placement of NG tube STAT. Place NG tube per policy..." On 5/31/2012 at 6:55 a.m., the resident was transferred to the [specialist physician] center for placement of a g/tube.		feeding	

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	During an interview with LPN #1 on 9/17/2012 at 12:05 p.m., she indicated the resident would often say that "it hurt" when referring to the NG tube and that she thought this might have been the reason for the resident pulling it out. During an interview with LPN #2 on 9/17/2012 at 1:20 p.m. and again at 2:40 p.m., she indicated "there were concerns about taking the resident back with an NG tube as I was concerned that due to the resident's dementia, she might pull it out and not leave it in place. It's not something normal, felt weird to her. My Administrator and Nurse Consultant were aware of my concerns." This Federal tag is related to Complaint IN00115675. 3.1-44(a)(2)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately document one resident's correct dosage and start date of Coumadin on the monthly physician orders before the physician signed them (Resident #E); and accurately document one resident's order for no fluid restrictions on the Nutritional Risk Assessment and dietary progress notes (Resident #C). This deficient practice affected 2 of 6 residents reviewed for accuracy of the clinical records in a sample of 6 residents. Findings included: 1. Review of the clinical record for Resident #E on 9/18/2012 at 9:45 a.m., indicated the resident was admitted to the	F0514	What corrective actions will be accomplished for those residents found to ha ve been affected by the deficient practiceResident E did not have a negative outcome related to the alleged deficiant practice. Resident E's medical record is up to date designating the correct start date and dosage of coumadinResident C's dietary progress notes/ nutritional risk assessment have been updated to reflect resident's current condition relateing to fluid restrictions.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be takenAll residents have the potential to be affected by the alleged deficient practicesLicensed nurses completing monthly Re-writes will be inserviced on completing accurately to reflect residents	10/12/2012

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	facility from another nursing home on 8/4/2012 and had diagnoses which included, but were not limited to: vascular dementia with disturbance of mood and behavior, panic disorder without agoraphobia, anxiety, gastrostomy tube placement, dysphagia and hemiplegia. Review of the September 2012 Monthly Physician Orders (re-writes) indicated the re-writes were checked by LPN #2 on 8/30/2012 and signed off as "correct". The monthly re-writes included an order for Coumadin (a blood thinner) 3 mg [milligrams] - take 1 tablet per g-tube [gastrostomy] once daily with an order date of 8/4/2012. The monthly re-writes were also then signed by the physician on 9/6/2012. Review of the telephone orders indicated the resident's Coumadin had been discontinued on 8/11/2012 and not re-started until 9/2/2012 with a new order for Coumadin 2 mg po [by mouth] Q [daily] at 5 p.m. During an interview on 9/18/2012 at 4:30 p.m., LPN #2 indicated the next month's physician re-writes were supposed to be matched against any telephone or new orders received in the last month. On 9/18/2012 at 3:30 p.m., the Nurse		current plan of care, matched against any new telephone or new orders recieved in the last month and any discontinued order to be crossed out with a single line, initialed and dated as well as yellowed out by the SDC/designee on or before 10/10/12. Post test included.Licensed nurses and dietary employees will be in-serviced on communication system for dietary changes by the DNS/designee on or before 10/10/12. Post test included.A final check for re-writes will be completed by the charge nurse on night shift the night of change over to ensure orders are accurate.100% audit of dietary progress notes and nutritional risk assessments for residents on a fluid restriction will be reviewed to ensure accuracy.All dietary changes will be reviewed in the clinical meeting by the IDT. Any dietary changes will be communicated to dietary using the dietary communication form.Non-compliance with procedures will result in further education including disciplinary actionThe DNS/designess is responsible for compliance.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurLicensed nurses completing monthly Re-writes will be inserviced on completing accurately to reflect residents current plan of care,	

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	Consultant presented a copy of the facility's current policy on "Reviewing And Correcting The Physician's Re-Write Forms, Medication And Treatment Records". Review of this policy at this time included, but was not limited to: "Procedure: Upon receipt of the monthly medication administration records and the physician order sheets, the nurse shall carefully inspect each residents' record for accuracy and make any necessary corrections. It is important that these directions are followed when correcting the physician's order sheet and medication administration, and treatment records:...Signed and date each page indicating the Write "D/C" at the end of the order and enter date and initials/signature..." 2. Review of the clinical record for Resident #C on 9/17/2012 at 3:50 p.m., indicated that the resident was re-admitted to the facility on 8/24/2012 with diagnoses which included, but were not limited to: end stage renal disease, diabetes mellitus, dialysis, and renal failure. Review of the 9/1/2012 Nutrition Risk Assessment indicated the resident was on fluid restrictions of 1500 cc [cubic centimeters] per day. A 9/1/2012 at 8:22		matched against any new telephone or new orders recieved in the last month and any discontinued order to be crossed out with a single line, initialed and dated as well as yellowed out by the SDC/designee on or before 10/10/12. Post test included.Licensed nurses and dietary staff will be in-serviced on communication system for dietary changes by the DNS/designee on or before 10/10/12. Post test included.A final check for re-writes will be completed by the charge nurse on night shift the night of change over to ensure orders are accurate.100% audit of dietary progress notes and nutritional risk assessments by t he RD/designee for residents with fluid restrictions will be reviewed to ensure accuracy.All dietary changes will be reviewed in the clinical meeting by the IDT. Any dietary changes will be communicated to dietary using the dietary communication form.Non-compliance with procedures will result in further education including disciplinary actionThe DNS/designess is responsible for compliance.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The CQI audit tool for pharmacy services will be utilized weekly x4, monthly x6 and quarterly thereafter.The CQI tool-dietician recommendations will be	

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	p.m. progress note by dietary also indicated the resident was receiving 1500 ml [milliliters] fluid restriction per day due to DM [diabetes], renal insuff [insufficiency] and HTN [hypertension]. On 8/24/2012, review of the re-admission orders from the hospital to the facility failed to locate an order for the resident to be on fluid restrictions. The Nutrition Risk Assessment and progress note were not corrected until 9/4/2012 when the Consultant Dietitian completed a new Nutrition Risk Assessment which reflected that she had verified with the nurse that the fluid restrictions had been discontinued. This Federal tag is related to Complaint IN00115675. 3.1-50(a)(2)		utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan implemented for threshold below 95%	